

3 Rehabilitative and Health Related Services Guidelines

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3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid rehabilitative options and health related services provided by therapists, school districts/Idaho Infant Toddler Program (ITP), developmental disabilities agencies (DDAs), and psychosocial rehabilitation agencies (PSR) as deemed appropriate by DHW. It addresses the following:

- School District/Infant Toddler Program (ITP) Service Policy
- Developmental Disabilities Agency Policy
- Rehabilitative Mental Health Services Policy
- Prior authorization
- Claims payment
- Electronic claims billing
- Paper claims billing

Note: Services provided by DDAs and PSRs for participants covered under the Medicaid Basic Plan Benefits are limited to diagnostic and evaluation procedures only.

3.1.2 Payment

Medicaid reimburses rehabilitative and health related services on a fee-for-service basis. Providers' charges to Medicaid shall be based on reimbursement rates established by the Department for their specific provider type and specialty and shall not exceed the lowest charge of the provider to others for the same service, regardless of payment source.

Rehabilitation and health related services must be billed by providers using the appropriate procedure codes, or health related service codes.

DDA and PSR providers must check eligibility to see if the participant is enrolled in Healthy Connections (HC), Idaho's Medicaid managed care program. School-based service providers are exempt from HC referral numbers to be included on claims. If the participant is enrolled, there are certain guidelines that must be followed to ensure reimbursement for providing Medicaid-covered services.

See **Section 1.5** for more on Healthy Connections guidelines.

3.1.3 Place of Service Codes

Enter the appropriate numeric code in the place of service box on the CMS-1500 claim form or in the appropriate field when billing electronically.

- 03** — School
- 11** — Office (DDA Center)
- 12** — Home (of participant)
- 99** — Other Place of Service (Community)

3.2 School District/Infant Toddler Program (ITP) Service Policy

3.2.1 Overview

Enrolled school districts and Infant Toddler Programs (ITP) may receive Medicaid reimbursement for rehabilitative and health related services. Schools and Infant Toddler Programs may bill for the following services provided to eligible students when recommended or referred by a physician or other practitioner of the healing arts (physician's assistant, nurse practitioner, or clinical nurse specialist):

- Annual IEP/IFSP or SP (Plan) development
- Audio logical/speech evaluation/therapy
- Collateral contact
- Developmental evaluation/therapy
- Intensive behavioral intervention
- Interpretative services – refer to section 2.1.1.5, Interpretation Services in General Billing Information. Call the Idaho *Careline* at (800) 926-2588 to locate an interpreter in your area.
- Medical equipment and supplies
- Occupational evaluation/therapy
- Personal care services
- Physical therapy/evaluation and treatment
- Psychological evaluation/therapy includes psychometric testing
- Psychosocial rehabilitation evaluation/therapy
- Skilled nursing services
- Social history and evaluation
- Transportation services

3.2.2 Related Services Definition

Related services are defined as the covered rehabilitative and health related services listed in IDAPA 16.03.09.564, which are provided by school districts/ITPs to certain students with disabilities who are enrolled in the Idaho Medicaid program.

Eligibility for these students is determined using State Department of Education minimum eligibility criteria and assessment procedures (IDAPA 08.02.03, "Rules Governing Thoroughness"). Eligibility for children birth to three (3) years of age is determined for those who are identified as needing early intervention services due to a developmental delay or disability in accordance with the eligibility criteria for the ITP.

3.2.3 School Districts/Idaho Infant Toddler Program Eligibility (ITP)

To be eligible for medical assistance reimbursement for covered services, a student must:

- Be identified as having an educational disability and be eligible for special education **or**, for children birth to three (3) years of age, be

- identified as needing early intervention services due to a developmental delay or disability, or be eligible for the ITP.
- Have an individualized education program (IEP) or individualized family service plan (IFSP) or services plan (SP) which indicates the need for one or more medically necessary health-related services.
- Be 21 years of age or younger and the semester in which his twenty-first birthday falls is not finished.
- Be eligible for Medicaid.
- Be eligible for the service for which the school district or ITP is seeking reimbursement.
- Be served by a school district, ITP, or a cooperative-service agency, as defined by Idaho Code 33.03.317.

3.2.4 Evaluation and Diagnostic Services

Evaluations must be recommended or referred by a physician or other practitioner of the healing arts (nurse practitioner, physician's assistant, clinical nurse specialist) and completed within 30 days of the date parental consent is obtained. Subsequent (annual) evaluations require only written notice to the parent(s).

3.2.5 Record Keeping

The school district/ITP records must contain the following information on each client:

- Referrals
- Evaluations
- Individualized Education Program (IEP), Individualized Family Service Plan (IFSP) or Service Plan (SP)
- Service Detail Report and Activity Record
- Other documentation as listed in 3.2.5.5

3.2.5.1 Referrals

Physician's orders should be located in the student's file or the physician may sign the IEP/IFSP/SP for evaluations and therapies billed to Medicaid. A physician's order is required for services and/or evaluations. It is preferred that the order is from the student's primary care provider if the student is on the HC program, however, it is not required. A sample referral form is available for your use at www.sde.state.id.us/specialed.

3.2.5.2 Evaluations

All evaluations must support services billed to Medicaid. Evaluations must be updated as needed and accurately reflect the student's current status. They must include the following information:

- Reason the student was referred for evaluation
- Diagnosis
- Student's strengths, needs, and interests

- Recommended interventions for identified needs
- Dated signature of professional completing the evaluation

3.2.5.3 Individualized Education Program (IEP) / Individualized Family Service Plan (IFSP)/ Services Plan (SP)

The IEP/IFSP/SP must include the type, frequency and duration of the service(s) provided, the title of the provider(s), and where the service will be provided if the service is provided outside of the school setting, i.e., home.

Example: Speech Therapy group 2 times per wk 30 minutes by Speech professional

The IEP/IFSP/SP must also contain goals and objectives for each of the identified needs. If the goals and objectives are kept separate from the main IEP/IFSP/SP body, the IEP/IFSP/SP must list where the goals and objectives can be located. Goals and objectives must be updated to reflect the current therapy, evaluation, or service that is being provided and billed to Medicaid.

3.2.5.4 Service Detail Report

A service detail report (SDR) must be completed at the time the service was provided. The SDR must include:

- Name of the student
- Name and title of the person providing the service
- Date, time, and duration of the service
- Description of the service provided
- Place of service, if provided in a location other than the school
- Student's response to the therapy

The service detail report may be included in one form by the therapy type or may be kept as a separate document.

3.2.5.5 Other Required Documentation

The school district/ITP must also maintain records that:

- Document student reviews and/or re-evaluations and any adjustments made to the treatment plan by the appropriate professionals. Documented review of progress toward service goals must occur at least every 120 days.
- Document supervisory visits conducted by professionals when paraprofessionals are utilized.
- Document provider qualifications including required certificates, licenses, and resumes indicating qualifications for position held.
- Document that the school district/ITP notified the student's parents of the health related services and equipment that the school district intended to bill to Medicaid. This notification must describe the service, service provider, and state the type, location, frequency and duration of the services that will be billed.

3.2.6 Intensive Behavioral Intervention

Intensive Behavioral Interventions (IBI) are individualized, comprehensive, proven interventions used on a short term, one-to-one basis that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interest. This service is only available to children, birth through the month of the child's twenty-first birthday (21) years of age, that demonstrate self-injurious, aggressive or severely maladaptive behavior and severe deficits in the areas of verbal and nonverbal communication, social interaction, or leisure and play skills.

3.2.6.1 Excluded Services

Under the Medicaid rules IDAPA 16.03.09.568, the following services are excluded from payment:

- Vocational services
- Educational services
- Recreational services

3.2.7 Collateral Contact

This service may be billed and paid as collateral contact when it is necessary to provide consultation or treatment direction about a Medicaid participant to a "significant other" in that participant's life (i.e., parent, guardian, or other individual having a primary care relationship to the participant). The service must be:

- Provided by the appropriate professional only
- Documented on the plan
- Documented in the progress notes
- Face-to-face or by telephone with the student's parent/guardian or primary care person

General staff training, regularly scheduled parent-teacher conferences, general parent education or treatment team meetings, even when the parent is present, are not reimbursable.

Under no circumstances can collateral contact be used to bill Medicaid for therapy to an ineligible person or be paid on behalf of a participant who is a resident of a hospital or a nursing facility (NF).

3.2.8 Provider Staff Qualifications

Medicaid reimburses for services provided by qualified professionals. The qualifications for providers of covered services are identified in IDAPA 16.03.09.569.

3.2.8.1 Paraprofessionals

Paraprofessionals, such as aides or therapy technicians, may be used by the school/ITP to provide developmental therapy, occupational therapy, physical therapy, Personal Care Services, and speech therapy if they are under the supervision of the appropriate professional.

The services provided by paraprofessionals must be within the scope of practice of an aide or therapy technician as defined by the scope of practice of the therapy professional. The portions of the IEP/IFSP/SP, which can be

delegated to the paraprofessional, as well as amount and scope of the supervision by the professional, must be identified in the IEP/IFSP/SP. See IDAPA 16.03.09.574 for further clarification related to the use of paraprofessionals.

Paraprofessionals **may not** conduct student evaluations, or establish or adjust the IEP/IFSP/SP goals. A student's goals and objectives must be reviewed and/or re-evaluated by the appropriate professional and the IEP/IFSP/SP adjusted as the professional's individual practice dictates.

Any change in the student's condition inconsistent with planned progress or treatment goals necessitates a documented re-evaluation by the professional before further treatment is carried out.

3.2.9 Estimated Annual Expenditure Match

The school district/ITP is responsible for certification of the state match portion of the Medicaid payment. The state match is calculated at the Federal Financial Participation (FFP) rate effective for the current year.

School districts/ITP must annually calculate and document, as part of their fiscal records, the non-Federal funds (maintenance of effort assurance) that have been designated as their certified match. Federal funds cannot be used as the state's portion of match for Medicaid service reimbursement. This documentation needs to include only the amount of dollars that have been certified and where the dollars originated. It is not necessary to designate how the dollars were spent for the purpose of certifying the match. The appropriate matching funds will be handled in the following manner:

- Schools will estimate the amount needed to meet match requirements based on their anticipated monthly billings.
- School districts will send Department of Health and Welfare (DHW) the matching funds, either by check or ACH electronic funds transfers.
- Matching funds will be held in an interest bearing trust account. The average daily balance during a month must exceed \$100 in order to receive interest for that month.
- The payments to the districts will include both the federal and non-federal share (matching funds).
- Matching funds from the district cannot be from federal funds or used to match any other federal funds.
- Checks should be sent to the DHW to the following address:

Department of Health and Welfare
Management Services Business Office
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5909

- Contact the Fiscal Operations Supervisor at the above address if the school district wants to make electronic fund transfer payments for the matching funds.
- Matching fund payments must be received and posted in advance of the weekly Medicaid payment cycle.
- If sufficient matching funds are not received in advance, all Medicaid payments to the school district will be suspended and the school

district will be notified of the shortage. Once sufficient matching funds are received, suspended payments will be processed and reimbursement will be made during the next payment cycle.

DHW will provide the school districts a monthly statement which will show the matching amounts received, interest earned, total claims paid, the matching funds used for the paid claims, and the balance of their funds in the trust account. The school districts will estimate the amount of their next billing and the amount of matching funds needed to pay DHW. The estimated match requirement may be adjusted up or down based on the remaining balance held in the trust account. If the school district has any questions, please direct those questions to the Fiscal Operations Supervisor.

3.2.10 Payment for Services

Payment for school district/ITP health related services must be in accordance with DHW-established rates. Providers must accept DHW's payment as payment in full. Providers may not bill Medicaid participants for the balance.

A contracted provider of the school program may not submit a separate claim to Medicaid as the performing provider for services billed under the school district/ITP provider number.

Third party recovery, such as private insurance, must be exhausted before DHW is billed. Proof of billing other third party payers is required.

Failure to provide services for which reimbursement has been received or to comply with these rules and regulations established by the Department is cause for recoupment of the Federal share of payments for services, sanctions, or both.

Providers must give DHW immediate access to all information required to review compliance with these rules and regulations.

See **Section 2.3.2** for more information on billing services that require prior authorization.

3.2.11 Prior Authorization (PA)

PA is required for certain medical equipment and supplies. Refer to the Medical Vendor Guidelines (DME – Durable Medical Equipment) for additional information.

PA will be based on a determination of medical necessity made by the Department or its designee.

If PA is required, the PA number must be indicated on the claim.

3.2.12 Procedure Codes

All claims submitted must contain one or more of the following five-digit health-related service procedure codes for billing. If a modifier is identified with the code, the modifier must be used with the code to bill for services.

3.2.12.1 Evaluation Services

Evaluation and information gathering services not necessarily associated with treatment are as follows:

Service	CPT or HCPCS Code	Description
Speech Evaluation by School District	92506	Evaluation of Speech, Language, Voice, Communication, and/or Auditory Processing and/or Aural Rehabilitation Status. Specify exact time. 1 unit = 15 minutes
Hearing Evaluation by School District	V5008	Hearing Screening Specify exact time. 1 unit = 15 minutes
Physical Therapy Evaluation by School District	97001	Physical Therapy Evaluation Specify exact time. 1 unit = 15 minutes
Occupational Therapy Evaluation by School District	97003	Occupational Therapy Evaluation Specify exact time. 1 unit = 15 minutes
Developmental Therapy Evaluation by School District	H2000	Comprehensive Multidisciplinary Evaluation Specify exact time. 1 unit = 15 minutes
Psychological Testing for Diagnosis/ Evaluation by School District	96101	Psychological testing (including psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS, Rorschach, MMPI) Per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report Specify exact time. 1 unit = 1 hour
Psychological Testing for Diagnosis/ Evaluation by School District	96102	Psychological testing (including psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS, MMPI) with qualified healthcare professional interpretation and report, administered by technician, per hour of technician time, face-to-face . 1 unit = 1 hour
Psychological Testing for Diagnosis/ Evaluation by School District	96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI), administered by a computer, with qualified healthcare professional interpretation and report. 1 unit = 1 test
Psychosocial Rehabilitation Evaluation by School District	H0031	Mental Health Assessment, by Non-Physician Specify exact time. 1 unit = 15 minutes
Psychiatric Diagnostic Interview Exam by School District	90801	Psychiatric Diagnostic Interview Examination Specify exact time. 1 unit = 15 minutes

Service	CPT or HCPCS Code	Description
Social History/Evaluation by School District	T1023	Screening to determine appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter.
Collateral Contact	90887	<p>Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons; or advising them how to assist patient.</p> <p>Specify exact time.</p> <p>1 unit = 15 minutes</p> <p>Note: This code cannot be used for staffing. Collateral contact cannot be provided by paraprofessionals.</p>
Annual IEP/IFSP/SP Plan Development	G9002 TM modifier required	Coordinated Care Fee, Maintenance Rate. Includes preparation and meetings for professionals involved in process. Reimbursed at flat rate per year.

3.2.12.2 Speech/Hearing Therapy

Treatment must be provided in accordance with the IEP/IFSP/SP. All providers must complete the evaluation, IEP/IFSP/SP, and all other required records to be paid. All speech and hearing claims must include one of the following HCPCS procedure codes:

Service	CPT Code	Description
Individual Speech/Hearing Therapy- Professional; by School District	92507 HO modifier required	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual Specify exact time. 1 unit = 15 minutes
Group Speech/Hearing Therapy - Professional; by School District	92508 HO modifier required	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); two or more individuals Specify exact time. 1 unit = 15 minutes
Individual Speech/Hearing Therapy - Technician; by School District	92507 HM modifier required	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual Specify exact time. 1 unit = 15 minutes
Group Speech/Hearing Therapy -Technician; by School District	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); two or more individuals Specify exact time. 1 unit = 15 minutes

3.2.12.3 *Physical Therapy*

Treatment must be provided by or under the supervision of a licensed physical therapist and in accordance with the IEP/IFSP/SP. All providers must complete the evaluation, IEP/IFSP/SP, and all other required records to be paid.

All physical therapy claim forms must include one of the following procedure codes:

Service	CPT Code	Description
Individual Physical Therapy; Professional, by School District	97110 HO modifier required	Therapeutic procedure, one or more areas; therapeutic exercises to develop strength and endurance, range of motion and flexibility; individual. Specify exact time. 1 unit = 15 minutes
Group Physical Therapy; Professional, by School District	97150 HO modifier required	Therapeutic procedure(s); two or more individuals. Specify exact time. 1 unit = 15 minutes
Individual Physical Therapy; Technician, by School District	97110	Therapeutic procedure, one or more areas; therapeutic exercises to develop strength and endurance, range of motion and flexibility; individual. Specify exact time. 1 unit = 15 minutes
Group Physical Therapy; Technician, by School District	97150	Therapeutic procedure(s); two or more individuals. Specify exact time. 1 unit = 15 minutes

Occupational Therapy

Occupational therapy services must be in accordance with the IEP/IFSP/SP.
All providers must complete the evaluation, IEP/IFSP/SP, and all other required records to be paid.

All occupational therapy claim forms must include one of the following procedure codes:

Service	CPT Code	Description
Individual Occupational Therapy - Professional; by School District	97530 HO modifier required	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), individual. Specify exact time. 1 unit = 15 minutes
Group Occupational Therapy - Professional; by School District	97530 HO and HQ modifiers required	Therapeutic activities, direct (one-on-one) contact by the provider (use of dynamic activities to improve functional performance); two or more individuals. Specify exact time. 1 unit = 15 minutes
Individual Occupational Therapy - Technician; by School District	97530	Therapeutic activities, direct (one-on-one) t contact by the provider (use of dynamic activities to improve functional performance); individual. Specify exact time. 1 unit = 15 minutes
Group Occupational Therapy - Technician; by School District	97530 HM and HQ modifiers required	Therapeutic activities, direct (one-on-one) contact by the provider (use of dynamic activities to improve functional performance); two or more individuals. Specify exact time. 1 unit = 15 minutes

3.2.12.4 Psychotherapy

Psychotherapy services must be provided in accordance with the IEP/IFSP/SP. All providers must complete the evaluation, IEP/IFSP/SP, and all other required records to be paid.

All psychotherapy claim forms must include one of the following procedure codes:

Service	CPT Code	Description
Individual Psychotherapy (Includes Interactive Psychotherapy); by School District	90899	Unlisted psychiatric service – This code was previously “Individual Psychiatric Therapy”. This code is reimbursed per 15 minute unit. NOTE: This is an interim code to be used by schools to be able to bill for psychotherapy services. This code replaces 90804, 90806, and 90808.
Group Psychotherapy; by School District	90853	Group psychotherapy (other than of a multiple – family group); two or more students. Professional only. Specify exact time. 1 unit = 15 minutes
Family Psychotherapy; by School District	90847	Family psychotherapy (conjoint psychotherapy) (with patient present). Professional only. Specify exact time. 1 unit = 15 minutes

3.2.12.5 Developmental Therapy

Medicaid reimbursement for individual and group developmental therapy is limited to those students who have a developmental disability according to the Department’s *Developmental Disability Determination Guidelines* located at the Special Education website - www.sde.state.id.us/specialed. On the website, from left menu, select **What we do**, and then select **Medicaid**.

Developmental therapy services must be provided in accordance with the IEP/IFSP/SP. All providers must complete the evaluation, IEP/IFSP/SP, and all other required records to be paid.

All developmental therapy claim forms must include one of the following procedure codes:

Service	HCPSC Code	Description
Individual Developmental Therapy; by School District	H2014	Skills Training and Development; individual. Specify exact time. 1 unit = 15 minutes
Group Developmental Therapy; by School District	H2014 HQ modifier required	Skills Training and Development; two or more individuals. Specify exact time. 1 unit = 15 minutes

3.2.12.6 Psychosocial Rehabilitation (PSR)

Medicaid reimbursement for individual and group PSR is limited to those students who have SED (Serious Emotional Disturbance) as defined in IDAPA 16.03.09.450.01. Psychosocial rehabilitation must be provided in accordance with the IEP/IFSP/SP. All providers must complete the evaluation, IEP/IFSP/SP, and all other required records to be paid.

All psychosocial rehabilitation claim forms must include one of the following procedure codes:

Service	HCPCS Code	Description
Individual Psychosocial Rehabilitation; by School District	H2017	Psychosocial Rehabilitation Services. Professional only; individual. Specify exact time. 1 unit = 15 minutes
Group Psychosocial Rehabilitation; by School District	H2017 HQ modifier required	Psychosocial Rehabilitation Services. Professional only; two or more individuals. Specify exact time. 1 unit = 15 minutes

3.2.12.7 Intensive Behavioral Interventions

Intensive Behavioral Intervention services should be listed on the Individual Education Plan (IEP) including the hours of service and the measurable outcomes.

Service	HCPCS Code	Description
Intensive Behavioral Intervention - Professional	H2019	Therapeutic Behavioral Services. 1 unit = 15 minutes
Intensive Behavioral Intervention - Paraprofessional	H2019 HM Modifier Required	Therapeutic Behavioral Services. 1 unit = 15 minutes
Intensive Behavioral Intervention Consultation – Professional	H0024	Behavioral health prevention information dissemination service (one-way direct or non-direct contact with service audiences to affect knowledge and attitude. Specify exact time. 1 unit = 15 minutes

3.2.12.8 Nursing Services

Nursing services must be provided in accordance with the IEP/IFSP/SP and include only those services that require skilled nursing by a licensed nurse. They do not include tasks that can be delegated to unlicensed assistive personnel by a registered nurse (RN) once proper training is provided and competency assessed.

All providers must complete the evaluation, IEP/IFSP/SP, and all other required records to be paid.

All nursing services claim forms must include one of the following procedure codes:

Service	HCPCS Code	Description
Nursing Services – LPN Skilled	T1003	LPN Services Specify exact time. 1 unit = 15 minutes
Nursing Services – RN Skilled	T1002 TD Modifier Required	RN Services Specify exact time. 1 unit = 15 minutes
Nursing Services – RN Oversight	T1002	RN Oversight Specify exact time. 1 unit = 15 minutes

3.2.12.9 Personal Care Services

Personal Care Services (PCS) include medically oriented tasks related to the student's physical or functional requirements such as basic personal care and grooming, assistance with eating, assistance with toileting, or other tasks delegated by an RN.

Personal care services must be:

- Ordered by a physician
- Based on a written plan of care that has been developed by an RN
- Supervised and monitored by an RN.

PCS must be provided in accordance with the IEP/IFSP/SP. PCS does not include tutorial assistance or assistance with educational tasks.

PCS providers must complete all required records to be paid.

All PCS claim forms must include one of the following procedure codes:

Service	HCPCS Code	Description
Personal Care Services-	T1004	Services of an Aide Specify exact time. 1 unit = 15 minutes
Personal Care Services – RN Assessment	G9001	Coordinated Care Fee, Initial Rate Flat rate paid for 1 assessment per year
Personal Care Services – Supervising RN visit	T1001	Nursing Assessment/Evaluation Flat rate paid for no more than 1 visit per month

3.2.12.10 Transportation

Medicaid reimbursement for transportation services can only be billed when:

- the student requires special transportation assistance
- the transportation occurs in a vehicle specially adapted to meet the needs of a student with a disability
- the student requires and receives another Medicaid reimbursable service billed by the school-based services provider, other than transportation, on the day that the transportation is being provided

Special transportation assistance can include a wheelchair lift or an attendant when the attendant is needed for the health and safety of the student. Both the Medicaid covered service and the need for transportation must be included on the IEP/IFSP/SP.

All providers must complete the evaluation, IEP/IFSP/SP, and all other required records to receive reimbursement.

All transportation claim forms must include at least one of the following procedure codes:

Service	HCPCS Code	Description
Transportation – Attendant rate	T2001	Non emergency transportation; patient attendant/escort. Specify exact time. 1 unit = 15 minutes
Transportation – Mileage rate	A0080	Non emergency transportation, per mile – vehicle provided by volunteer (Individual or organization), with no vested interest. Specify number of miles from pick-up to delivery.

3.2.12.11 Medical Equipment and Supplies

Authorization is limited to equipment and supplies primarily used and medically necessary for an individual student within the school setting. When necessary, authorization may also be given for equipment and supplies that are used in both the home and the school but are too large to transport back and forth or would be unsafe or unsanitary to transport back and forth. Other equipment and supplies (such as wheelchairs, diapers, dressing supplies, or catheters) which are used primarily at home, but also at school, are the responsibility of the primary caretakers to obtain and provide to the school.

Medical equipment and supplies which have been paid for by Medicaid funds are for the exclusive use of the student for whom they were ordered/billed. If the student transfers to another school, or leaves the school at which the equipment or supply was obtained, the supply or equipment must be transferred with the student.

Providers must complete an evaluation and all other required records and documentation to receive reimbursement.

All medical equipment claim forms must include the following procedure code:

Service	HCPCS Code	Description
Medical Equipment	E1399	Durable Medical Equipment, Miscellaneous 1 item = 1 unit Note: all items require prior authorization

3.3 Developmental Disabilities Agency Policy

3.3.1 Overview

Developmental Disabilities Agencies (DDAs) must provide rehabilitative services consistent with the needs of persons with developmental disabilities and as outlined on the participant's required plan of service. See IDAPA 16.04.11, "Developmental Disabilities Agencies (DDA)".

Note: Services provided by DDAs for participants covered under the Medicaid Basic plan are limited to diagnostic and evaluation procedures only.

See **Section 2** for more information on electronic billing.

3.3.2 Program Requirements

Refer to IDAPA 16.04.11 for evaluation, plan, and record keeping requirements for DDAs plan of service updates.

The interdisciplinary team must meet at least annually, or more often if necessary, to review and update the plan to reflect any changes in the needs or status of the participant.

3.3.2.1 Covered Service Limits

Twelve (12) hours is the maximum amount reimbursable in any calendar year for each participant for a combination of all evaluation, assessment and diagnostic services billed by all therapy providers.

Only one type of therapy is reimbursed during any single time period. Personal Care Services are not considered therapy for the purpose of this description. No therapy service is reimbursed during periods when the participant is being transported to and from the agency. For specific therapy limitations, based on type of service, see the appropriate sections of these guidelines.

3.3.2.2 Non-covered Services

Under the Medicaid rules for DDAs, the following services are **excluded** from payment:

- Vocational services
- Educational services
- Recreational services

3.3.3 Prior Authorization (PA)

DDA services for adults require prior authorization (PA) from the Department or its designee. If PA is required, the PA number must be indicated on the claim, or the payment will be denied. PAs are valid for one year from the date of authorization by Medicaid unless otherwise indicated on the approval.

When requesting PA, specify which service will be rendered.

When billing electronically, more than one PA number is allowed on the claim.

For Healthy Connections (HC) clients, PA will be denied if the requesting provider is not the primary care provider or a referral has not been obtained.

See **Section 2.3.2** for more information on billing services that require prior authorization.

3.3.3.1 Case Record Format

The case record must be divided into program and discipline areas identified by tabs, including plan of service, medical, social, psychological, speech, and developmental, as applicable).

3.3.3.2 Record Keeping

To facilitate payment from Medicaid, DDA records must contain the following information on each participant:

- Face sheet — Profile sheet containing necessary identifying information on the participant and family, eligibility documents, and Medicaid number.
- Physician's order — A written order signed and dated by the physician for all assessments completed.
- Social history — Social history and assessment containing relevant social information on the participant and family.
- History/physical — A medical history and physical examination completed and signed by a physician.
- Assessments — Assessment forms, as applicable, and narrative reports signed and dated by the respective examiners for each discipline covering those items assessed and recommendations for services.

3.3.4 Collateral Contact

Contact may be billed and paid as collateral contact when it is necessary to provide consultation or treatment direction about a Medicaid participant to a "significant other" in that participant's life (i.e., parent, guardian, or other individual having a primary treatment relationship to the participant). The service must be:

- Authorized on the plan of service; and
- Documented in the progress notes

Under no circumstances can collateral contact be used to bill Medicaid for therapy to an ineligible person, or be paid on behalf of a participant who is a resident of a public institution or a nursing facility (NF), including an intermediate care facility for the mentally retarded (ICF/MR). Refer to IDAPA 16.03.09.120 for specific requirements.

3.3.5 Psychotherapy

Medicaid reimbursement for individual and group psychotherapy services is limited to a maximum of 45 hours in a calendar year and includes the following:

- Individual psychotherapy provided in accordance with the plan of service
- Group psychotherapy in accordance with the plan of service
- Family psychotherapy, which must include the participant and at least one other family member in accordance with the plan of service
- Individual and group interactive psychotherapy in accordance with the plan of service

Interactive psychiatric diagnostic interview examination is typically furnished to children. It involves the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a patient. It is used when a patient has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment or the receptive communication skills to understand the clinician if he/she was to use ordinary adult language for communication.

Psychotherapy services must be provided by appropriately credentialed professionals only. Please refer to IDAPA 16.03.09.469.10a-j for a complete listing of qualified professionals.

3.3.6 Community Crisis Supports

Community Crisis Support includes intervention for participants in crisis situations to ensure their health and safety or prevent hospitalization or incarceration of a consumer. Community Crisis Support may include:

- Loss of housing, employment, or reduction of income
- Risk of incarceration
- Risk of physical harm
- Family altercation or other emergencies

Community Crisis Support is the choice of the participant and may be billed by Service Coordinators, Plan Developers (must be a targeted service coordinator (TSC), Plan Monitors, DDAs and all DD and ISSH Waiver providers **except**:

- Specialized Medical Equipment Agencies
- Non-Medical Transportation Providers
- Personal Emergency Response Agencies
- Home Delivered Meal Providers

Community Crisis Supports is limited to a maximum of 20 hours per crisis for a period of 5 consecutive days. Services may not exceed 20 hours per crisis.

The Regional Care Manager will review and authorize each crisis service to make determination for appropriateness and financial reimbursement. Providers must get either a written or verbal approval for Community Crisis Supports prior to billing.

Providers must identify on the Crisis Authorization Worksheet the factors contributing to the crisis and develop a proactive strategy that will address the factors that result in crisis.

3.3.7 Speech/Hearing Therapy

Speech and hearing therapy services are limited to 250 treatment sessions per calendar year. Treatment must be rendered by a licensed speech-language pathologist who possesses a certificate of clinical competence in speech-language pathology from the American Speech, Hearing and Language Association (ASHA) or will be eligible for certification within one (1) year of employment with the DDA.

3.3.8 Physical Therapy

Physical therapy services are limited to 25 treatment visits per calendar year. Treatment must be provided directly by a licensed physical therapist. Aides or therapy technicians may assist with physical therapy services only when a physical therapist is present.

3.3.9 Developmental and Occupational Therapy Services

The combination of developmental and occupational therapy services, IBI and adult day care are limited to 30 hours weekly. Developmental therapy may be provided seven days a week as long as the hours per week do not exceed the 30-hour limit. When billing for services, bill for the calendar week from Sunday through Saturday. Services must be consecutive dates when billing a date span.

Only a licensed occupational therapist may provide occupational therapy. This therapy must be in accordance with the plan of service.

Developmental therapy must be provided in accordance with IDAPA 16.04.11, "Developmental Disabilities Agencies (DDA)".

3.3.10 Intensive Behavioral Intervention

Intensive Behavioral Interventions are individualized, comprehensive, proven interventions used on a short term, one-to-one basis that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interest. This service is only available to children with developmental disabilities through the month of their 21st birthday who demonstrate self-injurious, aggressive or severely maladaptive behavior and severe deficits in the areas of verbal and nonverbal communication; or social interaction; or leisure and play skills.

3.3.11 Specialized Services to Nursing Facility Clients

Medicaid authorizes developmental therapy and psychotherapy for nursing facility clients who meet the following criteria:

- The participant has been identified through the initial Pre-Admission Screening Annual Resident Review (PASARR) process as being mentally retarded or having a related condition.
- The participant has been identified through the PASARR level II process as requiring developmental therapy and psychotherapy.
- The participant, when informed of his/her options for service delivery, chooses a DDA to provide that service.
- Services are provided in accordance with the plan of service and are supported by the assessment, directed toward the achievement of specific measurable objectives, and include target dates for completion.

The RMS is responsible for assuring the participant is identified as needing specialized services and for assigning a PA number to the agencies. The PA number must be entered on the claims submitted to EDS for payment.

Providers who bill for specialized services to nursing facility participants should use their usual agency based procedure codes.

3.3.12 Procedure Codes

The Idaho Medicaid Program uses the following procedure codes. All claims submitted must contain one or more of the following five-digit procedure codes for billing DDA services.

3.3.12.1 General Services

Procedure codes for evaluation and information gathering services not necessarily associated with treatment are as follows:

Service	CPT or HCPCS Code	Description
Psychological Test for Diagnosis and Assessment	96101	Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS, Rorschach, MMPI) per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report. 1 unit = 1 hour
Psychological Test for Diagnosis and Assessment	96102	Psychological testing (including psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS, MMPI) with qualified healthcare professional interpretation and report, administered by technician, per hour of technician time, face-to-face . 1 unit = 1 hour
Psychological Test for Diagnosis and Assessment	96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI), administered by a computer, with qualified healthcare professional interpretation and report. 1 unit = 1 test
Psychiatric Diagnostic Interview	90801	Psychiatric diagnostic interview examination. Physicians should use U1 modifier 1 unit = 15 minutes
Medical/Social History	T1028	Assessment of home, physical and family environment, to determine suitability to meet participant's medical needs. This service may be performed by LSW or RN as well as other qualified staff. This code should be used as part of the initial intake only. It is not considered an ongoing service. Specify exact time. 1 unit = 15 minutes
Collateral Contact	90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist participant. This code cannot be used for staffing. Specify exact time. 1 unit = 15 minutes
Community Crisis Supports	H2011	Intervention for participant in crisis situations. (See Information Release 2003-89). Service is limited to a maximum of 20 hours per crisis for 5 consecutive days. Service may not exceed 20 hours per crisis. 1 unit = 15 minutes
Interpreter, Non-certified	8296A	Interpretive Services. 1 unit = 1 hour

3.3.12.2 Speech/Hearing Therapy

Speech and hearing therapy services are limited to 250 treatment sessions (visits) per calendar year. Treatment must be provided by individuals eligible for ASHA certification in accordance with the IEP/IFSP/SP.

Services must be based on evaluation of the participant, IAP, and all other required documentation to be paid. All speech and hearing claims must include one of the following procedure codes:

Service	CPT Code	Description
Speech and Language Assessment	92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status. Specify exact time. 1 unit = 15 minutes
Individual Speech and Hearing Therapy	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation; individual). Specify exact time. 1 unit = 15 minutes
Group Speech and Hearing Therapy	92508	Treatment of speech, language, voice, communication and/or auditory processing disorder (includes aural rehabilitation); two or more individuals. Specify exact time. 1 unit = 15 minutes

3.3.12.3 Physical Therapy

Physical therapy services are limited to 25 treatment visits per calendar year. Treatment must be provided by or under the direct supervision of a licensed physical therapist.

Services must be based on evaluation of the participant, IAP, and all other required documentation to be paid. All physical therapy claim forms must include one of the following procedure codes:

Service	CPT Code	Description
Physical Therapy Assessment	97001	Physical therapy evaluation. Specify exact time. 1 unit = 15 minutes
Individual Physical Therapy	97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility; individual. Specify exact time. 1 unit = 15 minutes
Group Physical Therapy	97150	Therapeutic procedure(s); two or more individuals. Specify exact time. 1 unit = 15 minutes

3.3.12.4 Developmental and Occupational Therapy

Occupational and developmental therapy services and adult day care are limited to a combined total of 30 hours weekly. Treatment must be provided by or under the supervision of a registered occupational therapist or qualified developmental specialist. Evaluations can only be completed by a professional.

All services must be based on evaluation of the participant, documented on the ISP, and all other required documentation to be paid. All occupational or developmental therapy claim forms must include one of the following procedure codes:

Service	CPT or HCPCS Code	Description
Comprehensive Developmental Therapy Assessment	H2000	Comprehensive Multidisciplinary Evaluation. Specify exact time. 1 unit = 15 minutes
Occupational Therapy Assessment	97003	Occupational Therapy Evaluation. Specify exact time. 1 unit = 15 minutes
Developmental Therapy Individual – Center	H2014	Skills training and development. Specify exact time. 1 unit = 15 minutes
Developmental Therapy, Individual - Home/community	H2021	Community Based Wrap-Around Services; individual. Specify exact time. 1 unit = 15 minutes
Developmental Therapy, Group Home/community	H2021 HQ modifier required	Community Based Wrap-Around Services; two or more individuals. Specify exact time. 1 unit = 15 minutes
Developmental Therapy Group – Center	H2014 HQ modifier required	Skills training and development; two or more individuals. Specify exact time. 1 unit = 15 minutes
Occupational Therapy (Individual)	97535	Self-care/home management training (e.g., Activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider; individual Specify exact time. 1 unit = 15 minutes
Occupational Therapy (Group)	97535 HQ Modifier Required	Self-care/home management training (e.g., Activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider; two or more individuals. Specify exact time. 1 unit = 15 minutes
Home/ Community Individual Developmental Therapy (PA required for Adults in the DD Care Management Process)	97537 Effective for PA'd plans containing dates of service on or after July 1, 2005	Home/community and/or work reintegration training; individual. 1 unit = 15 minutes

Service	CPT or HCPCS Code	Description
Home/Community Group Developmental Therapy (PA required for Adults in the DD Care Management Process)	97537 HQ Effective for PA'd plans containing dates of service on or after July 1, 2005	Home/community and/or work reintegration training; two or more individuals. 1 unit = 15 minutes
Center-based Individual Developmental Therapy 2005 (PA required for Adults in the DD Care Management Process)	H2032 Effective for PA'd plans containing dates of service on or after July 1, 2005.	Individual activity therapy. 1 unit = 15 minutes
Center-based Group Developmental therapy (PA required for Adults in the DD Care Management Process)	H2032 HQ Effective for PA'd plans containing dates of service on or after July 1, 2005	Group activity therapy. 1 unit = 15 minutes

3.3.12.5 Psychotherapy Treatment

Medicaid reimbursement for individual and group psychotherapy services is limited to a maximum of 45 hours in a calendar year. Psychotherapy services must be provided by the professionals listed in IDAPA 16.03.09.69.06. All providers must complete the evaluation, IEP/IFSP/SP, and all other required records to be paid. All psychotherapy claim forms must include one of the following procedure codes:

Service	CPT or HCPCS Code	Description
Individual Medical Psychotherapy	H0004	Behavioral Health Counseling and therapy; individual. Physicians use U1 modifier. Specify exact time. 1 unit = 15 minutes
Group Medical Psychotherapy	90853	Psychotherapy (other than of a multiple-family group); Two or more individuals. Physicians use U1 modifier. Specify exact time. 1 unit = 15 minutes
Family Medical Psychotherapy	90847	Family psychotherapy (conjoint psychotherapy)(with patient present). Physicians use U1 modifier. Specify exact time. 1 unit = 15 minutes

3.3.12.6 Intensive Behavioral Intervention

Intensive Behavioral Intervention services must be PA'd by the Department and must list the need for the service on the plan of service including the hours of service and the measurable outcomes.

Service	CPT or HCPCS Code	Description
Intensive Behavioral Intervention - Professional	H2019	Therapeutic Behavioral Services. Specify exact time. 1 unit = 15 minutes
Intensive Behavioral Intervention - Paraprofessional	H2019 HM modifier required	Therapeutic Behavioral Services. Specify exact time. 1 unit = 15 minutes
Intensive Behavioral Intervention Consultation	H0024	Behavioral health prevention information dissemination service (one-way direct or non-direct contact with audiences to affect knowledge and attitude). Specify exact time. 1 unit = 15 minutes

3.3.12.7 Specialized Services to Nursing Facility Clients

Regional Medicaid Services (RMS) PA developmental therapy and psychotherapy services for nursing facility participants using the following procedure codes:

Service	CPT or HCPCS Code	Description
Developmental Therapy Evaluation for Nursing Facility Participants	H2000 U4 Modifier Required	Comprehensive Multidisciplinary Evaluation. 1 unit = 15 minutes
Developmental Therapy/Individual for Nursing Facility Participants	H2014 U4 modifier required	Skills training and development; individual. Specify exact time. 1 unit = 15 minutes
Developmental Therapy/Group for Nursing Facility Participants	H2014 U4 and HQ modifier required	Skills training and development; two or more individuals. Specify exact time. 1 unit = 15 minutes
Individual Psychotherapy for Nursing Home Participants	H0004 U4 modifier required	Behavioral Health Counseling and therapy; individual. Physicians use U1 modifier. Specify exact time. 1 unit = 15 minutes
Group Psychotherapy for Nursing Facility Participants	90853 U4 modifier required	Psychotherapy (other than of a multiple-family group); two or more individuals. Physicians use U1 modifier. Specify exact time. 1 unit = 15 minutes
Family Psychotherapy for Nursing Facility Participants	90847 U4 modifier required	Family psychotherapy (conjoint psychotherapy) (with patient present). Physicians use U1 modifier. Specify exact time. 1 unit = 15 minutes

3.4 Rehabilitative Mental Health Services Policy

3.4.1 Overview

Rehabilitative Mental Health Services (also called Rehab Option or PSR services) include treatment, rehabilitation, and supportive services. The goal of rehabilitative services is to reduce to a minimum a participant's mental disability and restore the participant to the highest possible functional level within the community.

Note: Services provided by PSR agencies for participants covered under the Medicaid Basic plan are limited to diagnostic and evaluation procedures only.

3.4.2 Provider Enrollment and Credentialing

In order to become enrolled as a PSR provider the provider applicant must meet the requirements established through the Credentialing Program. All existing PSR providers must meet the requirements of the Credentialing Program on a schedule established with the Department.

All locations where Medicaid PSR services are provided must be registered with the Department and must have a valid provider agreement.

3.4.3 Client Eligibility

Children with a serious emotional disturbance (SED) are eligible for rehabilitative mental health services. See IDAPA 16.03.09.450.01a.-e. for qualifying criteria. Also, participants who are 18 years of age or older with a diagnosis of severe and persistent mental illness that directly impacts at least two identified functional areas on either a continuous or an intermittent basis are eligible for these services. Specific diagnoses and functional information can be found at IDAPA 16.03.09.450.02.

3.4.4 Prior Authorization (PA)

PA is required for all Rehabilitative Mental Health services and is obtained from the Mental Health Authority (MHA).

3.4.5 Non-Covered Services

Treatment services are not reimbursed if rendered to participants residing in inpatient medical facilities (nursing homes) unless specifically approved by Regional Medicaid Services (RMS) through the Pre-Admission Screening Annual Resident Review (PASARR) program. Also excluded are recreational and social activities, job training, job placement services, or job specific interventions, staff performance of household tasks and chores, and treatment services for persons other than the identified participant.

Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the services, leaving messages, scheduling appointments with the Medicaid service coordinator, transporting participants, or documenting services.

3.4.6 Covered Services

A combination of any evaluation or diagnostic services is limited to a maximum of six (6) hours annually under the psychosocial rehabilitation (PSR) program.

See **Section 2.3.2** for more information on billing services that require prior authorization.

Note: Participants are subject to a yearly limit of 12 hours for all mental health related evaluation and diagnostic services.

3.4.7 Limitations

Psychotherapy

Individual, family, and group psychotherapy services are limited to a maximum of twenty-four (24) hours annually.

Crisis Intervention Services

Community crisis support services are limited to a maximum of twenty (20) hours during any consecutive five (5) day period. Ongoing crisis services require PA from the MHA. Crisis services should be documented and maintained in the participant's file, along with the written approval.

Psychosocial Rehabilitation (PSR)

Any combination of individual and group PSR services is limited to twenty (20) hours per week. Services in excess of twenty (20) hours require additional review and PA by the MHA.

3.4.8 Payment

Payment for rehab option services is made directly to the provider agency in accordance with the rates established by the Department of Health and Welfare (DHW) for the specific services.

For services paid at the fifteen (15) minute incremental rate, providers will not be reimbursed for more than one (1) contact during a single fifteen (15) minute time period.

3.4.9 Record Keeping

Each agency is required to maintain records on all services provided to Medicaid participants. See IDAPA 16.03.09.457.01-09 for specific requirements. The records must contain a current treatment plan signed by a physician. Services must be provided in accordance with the current treatment plan, and the records must contain **all** of the following:

- The name of the participant and the provider
- The date, time, duration of service, and justification
- Documentation of service provided, place of service, and response of the participant
- The legible signature and date, with degree credentials listed of the staff member performing the service
- The participant's signature of choice of provider
- Documentation of review of progress/reassessment and closure of services

Note: Services not prior authorized by the Mental Health Authority (MHA) will not be paid or will be subject to recoupment by Idaho Medicaid.

3.4.10 Procedure Codes

Service	CPT or HCPCS Code	Description
Ongoing Community Crisis Support	H2011	Crisis Intervention. PA required. 1 unit = 15 minutes
Psychiatric Diagnostic Interview	90801	Psychiatric Diagnostic Interview Examination. Physicians should use U1 modifier. 1 unit = 15 minutes PA required.
Interactive Medical Psychiatric Diagnostic Exam	90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication. Physicians should use U1 modifier. 1 unit = 15 minutes PA required.
Psychological Test for Diagnosis and Evaluation	96101 no modifier allowed	Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS, Rorschach, MMPI) per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report 1 unit = 1 hour PA required.
Psychological Test for Diagnosis and Evaluation	96102 no modifier allowed	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI and WAIS), with qualified healthcare professional interpretation and report, administered by technician per hour of technician time, face-to-face 1 unit = 1 hour PA required.
Psychological Test for Diagnosis and Evaluation	96103 no modifier allowed	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI) administered by a computer, with qualified healthcare professional interpretation and report. 1 unit = 1 test PA required.
Rehabilitative Evaluation	H0031	Mental Health Assessment, by non physician. 1 unit = 15 minutes PA required.
Task Plan Development	H0032	Mental Health Service plan development, by non-physician. 1 unit = 15 minutes PA required.
Medical Report (Past record)	90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes. 1 unit = 1 report PA required.

Service	CPT or HCPCS Code	Description
Medical Report (New exam)	90889	Preparation of report of patient's psychiatric Status, history, treatment or progress (other than for legal or consultative purposes) for other physicians, agencies or insurance carriers. 1 unit = 1 report PA required.
Individual Medical Psychotherapy	90804 90806 90808	Psychotherapy, insight oriented, behavior modifying and /or supportive, in an office or outpatient facility, approximately 20 – 30 minutes face to face with patient (90804); individual. The code is based on length of time spent with the participant. Providers should select the code that is closest to duration of the session and bill the code as 1 unit. Physicians should use UA modifier. 90806 = 45-50 minutes, and 90808 = 75-80 minutes. PA required.
Group Medical Psychotherapy	90853	Psychotherapy (other than a multiple – family group); two or more individuals. Physicians should use U1 modifier. No modifier is allowed for other providers. 1 unit = 15 minutes PA required.
Family Medical Psychotherapy	90847	Family psychotherapy (conjoint psychotherapy with patient present). Physicians should use U1 modifier. No modifier is allowed for other providers. 1 unit =- 15 minutes PA required.
Pharmacologic Management	90862	Pharmacologic management, including prescription use, and review of medication with no more than minimal medical psychotherapy. This service may be billed by: Physician, Nurse Practitioner, Physician Assistant, Psychiatric Nurse Practitioner, or Clinical Nurse Specialist-Psychiatric. 1 unit = 1 visit PA required.
Individual Psychosocial Rehabilitative Services	H2017	Psychosocial Rehabilitation services; individual. 1 unit = 15 minutes PA required. Note: PSR services are covered for Enhanced Plan participants only.
Group Psychosocial Rehabilitative Services	H2014 HQ Modifier Required	Skills Training and Development. Physicians should use U1 modifier. 1 unit = 15 minutes PA required.
Face-to-Face Collateral Contact	90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient. 1 unit = 15 minutes PA required.

Service	CPT or HCPCS Code	Description
Telephone Collateral Contact	90887 HE modifier required	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient. 1 unit = 15 minutes PA required.
Collateral Contact Family Group	90887 HQ modifier required	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient. 1 unit = 15 minutes PA required.
Nursing Service Office Visit	T1001	Nursing Assessment/evaluation. Includes review of lab results; phone consultations with physician and/or participant regarding participant's present condition; phone contact with physician to obtain prescription refills. Note: These services must appear on treatment plan in order to be reimbursed. 1 unit = 15 minutes PA required.
Blood Draw	36415	Routine venipuncture for collection of specimen(s). 1 unit = 1 visit PA required.
Injection	90782	Therapeutic, prophylactic, or diagnostic injection (specify material injected); subcutaneous or intramuscular. 1 unit = 1 injection PA required.
Medication Supply	J3490	Unclassified drugs. Specify medication and dosage. Use of this code requires use of NDC. (National Drug Code). Note the drug code on the claim form in the comments field or the designated field on an electronic claim form. PA required.
Occupational Therapy Evaluation	97003	Occupational Therapy Evaluation. 1 unit = 15 minutes PA required.
Occupational Therapy, Individual	97535	Self-care/home management training (e.g., Activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider; individual. Specify exact time. 1 unit = 15 minutes PA required.
Individual Psychotherapy for Nursing Home Clients	H0004 U4 Modifier Required	Behavioral Health Counseling and therapy; individual. Physicians should use U1 modifier. 1 unit = 15 minutes PA required.

Service	CPT or HCPCS Code	Description
Group Psychotherapy for Nursing Facility Clients	90853 U4 Modifier Required	Psychotherapy; two or more individuals. Physicians should use U1 modifier. 1 unit = 15 minutes PA required.
Family Psychotherapy for Nursing Facility Clients	90847 U4 Modifier Required	Family psychotherapy (conjoint psychotherapy with patient present). Physicians should use U1 modifier. 1 unit = 15 minutes PA required.

3.5 Claim Billing

3.5.1 Which Claim Form to Use

All claims that do not require attachments may be billed electronically using vendor software or PES software provided by EDS at no cost.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year of the date of service.

3.5.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

3.5.2.1 Guidelines for Electronic Claims

Detail lines

Idaho Medicaid allows up to **50** detail lines for electronic HIPAA 837 Professional claims.

Referral number

A referral number is required on an electronic HIPAA 837 Professional claim when a client is referred by another provider. Use the referring providers' Medicaid provider number, unless the client is a Healthy Connections client. For Healthy Connections clients, enter the provider's Healthy Connections referral number.

Prior authorization (PA) numbers

Idaho Medicaid allows more than one prior authorization number per electronic HIPAA 837 Professional claim. PAs can be entered at the header or detail of the claim.

Modifiers

Up to **four** modifiers per detail are allowed on an electronic HIPAA 837 Professional claim.

Diagnosis codes

Idaho Medicaid allows up to **eight** diagnosis codes on an electronic HIPAA 837 Professional claim.

Electronic crossovers

Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

See **Section 2** for more information on electronic billing.

3.5.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms (formerly known as the HCFA 1500) to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

The CMS-1500 form can be used without changes for dates in the year 2000 and beyond. All dates must include the month, day, century, and year.

Example: July 4, 2006 is entered as 07/04/2006

3.5.3.1 *How to Complete the Paper Claim Form*

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- You can bill with a date span (From and To Dates of Service) **only if** services were provided on consecutive days.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed.
- Do not use staples or paperclips for attachments. Stack them behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.5.3.2 *Where To Mail the Paper Claim Form*

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.5.3.3 *Completing Specific Fields*

Consult the Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the seven-digit participant MID number exactly as it appears on the plastic participant MID card.
2	Patient's Name	Required	Enter the participant's name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial.

Field	Field Name	Use	Directions
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable	Required if field 11d is marked YES.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate yes or no if this condition is related to the participant's employment.
10b	Auto Accident?	Required	Indicate yes or no if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate yes or no if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections participant. Enter the referring physician's name.
17a	ID Number of Referring Physician	Required if applicable	Use this field when billing for a consultation or Healthy Connection participant. Enter the referring physician's Medicaid provider number. For Healthy Connections participants, enter the provider's Healthy Connections referral number.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	Enter the PA number from DHW, RMS, ACCESS, RMHA, EDS, Quality Improvement Organization (QIO), or MTU.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, year). Example: November 24, 2005 becomes 11242005 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24D 1	Procedure Code Number	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.

Field	Field Name	Use	Directions
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as three. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field 21.
24F	Charges	Required	Enter your usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H1	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook.
24I	EMG	Required if applicable	If the services performed are related to an emergency, mark this field with an X .
24K	Reserved for Local Use	Required if applicable	When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the provider rendering the service in Field 24K and the group provider number in field 33.
28	Total Charge	Required	Add the charges for each line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Enter the total charges, less amount entered in amount paid field.
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See Section 1.1.4 for more information.
33	Provider Name and Address	Required	Enter your name and address exactly as it appears on your provider enrollment acceptance letter or RA. If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33	GRP — Provider Number	Required	Enter your nine-digit Medicaid provider number.

3.5.3.4 Sample Paper Claim FormPLEASE
DO NOT
STAPLE
IN THIS
AREA

HEALTH INSURANCE CLAIM FORM									
PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)				1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)			
CITY		STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full Time <input type="checkbox"/> Student <input type="checkbox"/> Part-Time <input type="checkbox"/>		CITY		STATE	
ZIP CODE		TELEPHONE (include Area Code)				ZIP CODE		TELEPHONE (include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						b. EMPLOYER'S NAME OR SCHOOL NAME			
c. EMPLOYER'S NAME OR SCHOOL NAME						c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.									
SIGNED _____ DATE _____									
14. DATE OF CURRENT: MM DD YY				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)									
1. _____ 3. _____ 2. _____ 4. _____									
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER									
24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE									
1									
2									
3									
4									
5									
6									
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$	
29. AMOUNT PAID \$				30. BALANCE DUE \$					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.)				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #			
SIGNED _____ DATE _____				PIN# _____		GRP# _____			

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500